Council on Medical Assistance Program Oversight
Connecticut General Assembly

Report on Network Adequacy in Accordance to Special Act No. 13-7

Executive Summary

This report is submitted to the Council on Medical Assistance Program Oversight pursuant to Special Act No. 13-7, An Act Concerning an Adequate Provider Network to Ensure Positive Health Outcomes for Low Income Residents.

The network adequacy committee of the Council on Medical Assistance Program Oversight was formed to address the charge of the legislation.

As part of the process, the network adequacy committee invited providers who serve the Medicaid population to address the group about their concerns. Key areas in which concerns were expressed include the following:

- Audit – Requirements and Procedures
- Rates and Rate Setting
- Capacity- Provision of Services to Medicaid Beneficiaries
- Ordering, Prescribing, and Referring Requirements– Procedures for Non-Medicaid enrolled physicians

Subcommittees were formed to research the issues and develop recommendations. Reports and comments submitted as part of the process are located in Appendix A. The Department of Social Services (DSS) comments about the proposed recommendations are available in full in Appendix A. It should be noted that DSS raised concerns that some of the recommendations do not accurately reflect the current state and practice of the Connecticut Medicaid program.

DSS initiatives such as the Person-Centered Medical Home (PCMH), Obstetric Pay for Performance and, the Dental Health Partnership are modeling best practices in care delivery. Programs such as these should be promoted throughout the Medicaid program and monitored. The CT Health Policy Project published a recent report on the improvements in access, quality and care of the Connecticut's Medicaid Program. The report is located in Appendix A.

The Members and Contributors of this report are located in Appendix B.

The dates the workgroup met are located are located in Appendix C.

The participants of the subcommittees are members of the provider communities and associations. Their opinions and comments are reflected in the issues and solutions. The agency was given an opportunity to comment, their comments are included in the agency response section.

Audit Issues and Solutions

The following comments and concerns came from the audit issues and solutions subcommittee:

The audit workgroup **Audit Issues are:**

- The presumption of fraud and abuse in cases that may result from unintentional clerical errors;

- Most of the rules and regulations detailing billing processes are not transparent and are not appropriately shared with providers to date;

- That the extrapolation method of auditing used by DSS should be modified because this method is not precise enough for determining the number of payment errors or the amount of over payment to be collected;

- That the audit errors are caused by out of date codes and methods that require manual intervention and special procedures to handle and;

- Requiring providers to go to court as a first resort makes the process unduly adversarial.

The Audit Subcommittee proposed the following recommendations:

- That the extrapolation sampling process should be revised. The programs require extrapolation and assuming audit. Extrapolation should be performed across like claims and not across the entire claims universe;
- That the intensiveness of DSS audits should be based on past audit results and agencies with higher compliance risk should be targeted instead of agencies that have performed positively in past audits;
- That provider responsibility for pursuing appropriate third party liability (TPL) results in administrative burden on providers due to the labor intensive back-end review of services already provided and paid for;
- Consider Third Party Liability Process (TPL Process), that identifies appropriate payer (Medicaid or Medicare) up front;
- That an external or independent appeals process should be established;
- That the review process be changed; the DSS Assurance Department should develop more prospective review but should follow retrospective process for coming year per contract and;
- Provide information about the DSS audit process to Medicaid providers especially new physicians entering the CT Medical Assistance Program. A suggestion for a free training that would explain the proper entry of claims to avoid clerical errors.

Ordering Prescribing and Referring (OPR) Issues and Solutions

Under the Affordable Care Act, all providers, including ordering, prescribing, or referring (OPR) physicians, who provide services to HUSKY recipients must be enrolled in the Medical Assistance Program (CMAP). The OPR provider's NPI must be listed on every claim for services based on the order, prescription, or referral. At the time of implementation not all providers who performed OPR were enrolled into the CMAP network which caused some temporary problems. DSS provided some solutions during the process of the discussion (responses are below).

According to the participants in the subcommittee, the top issues in OPR are:

- Potential for significant access to care issues
  - Example: potential for patients to be discharged whose physicians refuse to enroll or don't understand why they need to enroll in the OPR;
  - Potential for significant decrease in access to quality care - due to lack of enrollment (by specialists) and issues with filling prescriptions (interns/residents)
- Many physicians still unaware of requirement and confused about enrollment or why they should enroll in the OPR Program.
- The provider look-up on Husky Health website is limited to just OPR enrolled.
- Lack of one clear document, which would explain how to enroll, for providers who are expected to enroll

The subcommittee suggested **the following recommendations to improve OPR:**

- Develop a common message for clients instructing them to follow up with their own physicians. Develop concise communication to currently enrolled and non-enrolled physicians clarifying the requirement
- Improve communication with other agencies and stakeholders in advance of rollout.
- Improve DSS website, provider look-up, and provider bulletins format.
  - Add separate look-up on Husky Health to include fully enrolled physicians, separating out physicians who still have capacity versus those not taking on any new cases. Provide an accurate list of all categories. This could also serve to improve network capacity issues.

Rates and Reimbursement Issues and Solutions
According to the participants of the group, the top issues are as follows:

- CT's Medicaid rates are currently too low to cover costs for providers and to attract the number of providers the state will need given increasing enrollment under the Affordable Care Act.
- Rates do not cover everything that must be done to adequately care for people with disabilities.

- There is a lack of transparency about the rate-setting process and significant lack of provider involvement and feedback.
- Some rates haven't changed since the programs were implemented in 2008.
- Rates should be adjusted annually for inflation.

Solutions and Recommendation

- Adopt fair and transparent compensation models and review the entire payment structure. Review payment models in other states have to see what they have done.
- Provide quicker payments to providers.
- Increase payment rates, especially for specialists so they will take referrals
- Expedite prior authorizations.
- Develop reimbursement methodologies that reflect time spent and complexity of services.
- Perform comprehensive review of CMS guidelines for behavioral health and services for individuals with disabilities Medicaid rates, and report how these guidelines match with the schedule of rates in Connecticut.
- Identify activities that are not reimbursed under the existing rate methodology. This exercise should take place with significant provider involvement and input;
- Adjust the Medicaid rate schedule so that all services coverable under the federal guidelines are included so that providers may bill for services and the state will maximize its revenue with the 50% match (in some cases, higher for behavioral health).

Capacity

According to the participants of the capacity subcommittee, their major concerns were as follows:

The issues are similar to the top issues discussed in the other subcommittees. Please refer to each section (rates/reimbursements, OPR and audit) for further recommendations.

- Access to care issues. A lack of healthcare workers in various specialty areas will make it difficult to meet the health care needs of additional Medicaid beneficiaries. Reasons why health care employers aren't hiring more staff:
  - Rates and reimbursement are too low to hire more qualified people
  - Administrative burdens required for audit requirements are sapping resources
  - OPR procedures are making it difficult for physicians to write prescriptions and for Medicaid members to get their prescriptions.
- Patients and providers are having a difficult time understanding and navigating through health care systems and programs.

- Providers would like to provide a comprehensive PCMH system in their offices but lack the capacity and infrastructure.

The workgroup proposed the **following solutions**:
- Expand the workforce by providing incentives for potential health care workers and students to stay and work in Connecticut. Collaborate with local associations for recruitment and retention.
- Have the Council on Medical Assistance Program Oversight review the ASO's current provider network and recruitment methods on a quarterly basis.
- Develop public service announcements about person-centered medical homes and how they will result in better care for Medicaid recipients. Educate and recruit all physician practices about the PCMH Program.
- Increase support for patient navigation services and increase patient education.
- Engage patients in their own care and develop strong patient-provider relationships. These are critical to making the system work because patients often seek their provider's advice. Many practices noted that better information both directly to patients and practices would ease that burden.
- Provide free telephonic translation/interpretation services and on-call translation services for Medicaid providers and beneficiaries.
- Research and consider other patient models of care for individuals with complex needs.

Response from the Department of Social Services

Audits
Administrative Burden
The Department continuously evaluates the procedures utilized to ensure that Medicaid is the payer of last resort and that our provider network appropriately bills all available third party coverage. We understand the administrative burden that some of these efforts may impose on our providers. At this very time, the Department is working with select representatives from the Connecticut Association of Healthcare at Home ("CAHCH") to address this matter. The workgroup has proposed some interesting enhancements to the exiting Medicare recovery project. The Department is optimistic that a solution that benefits all impacted parties will be achieved.

Provider Audits
The Department must stress that the purpose of the audit function administered by the Office of Quality Assurance is strictly a compliance function. The need for compliance in a multi-billion dollar public assistance program cannot be understated. The Connecticut Medical Assistance Programs are governed by a vast variety of policies and regulations and statutes. Yet, despite the complexity of these programs and rules, enrolled providers are entrusted to understand all applicable guidelines and accurately bill for all covered services. Most all providers are granted

the right to directly bill for goods and services rendered with relatively few upfront edits. The Office of Quality Assurance is responsible for ensuring both the fiscal and programmatic integrity of the Medical Assistance Programs. The Department believes that there is a direct correlation between poor billing compliance and the quality of the related medical services.

The Department has a long history of understanding the need for compliance audits and the value that audits bring to the Medical Assistance programs. The Department also understands that without a financial penalty for non-compliance, the audits would be rendered worthless. The investment in this compliance function has paid dividends. The Connecticut Medicaid program has one of the lowest payment error rates in the United States. The Centers for Medicaid and Medicare Services performs audits the payment accuracy all state Medicaid programs on a three year cycle. The FY 2012 published estimated error rate for Connecticut is 2.2%. This error rate is less than half of the national average and puts Connecticut in the top tier of Medicaid programs. Please see the following graph developed by CMS:

Figure 1: State Error Rate Relative to Other States and the National Error Rate
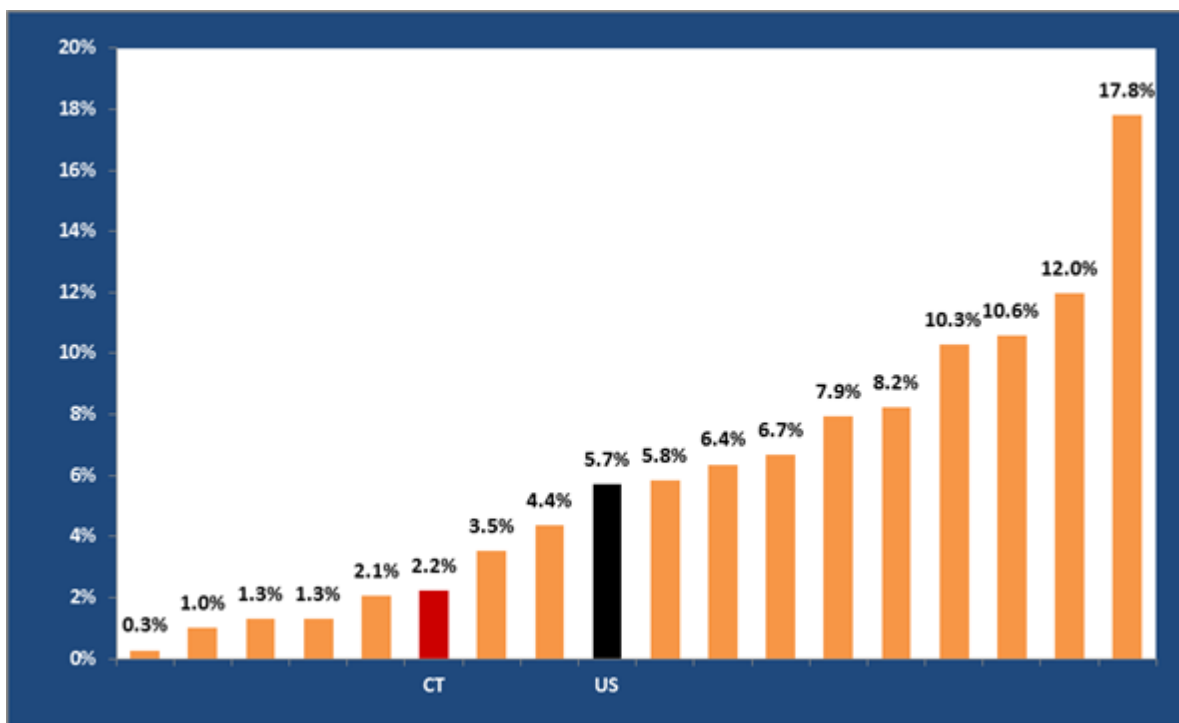
Connecticut's success is not by accident. It is a direct result of a historically strong audit and compliance effort.

Please see report for further agency comments.

OPR

DSS has fully implemented the ACA Ordering, Prescribing and Referring (OPR) requirements. With the exception of resolving participation by attending physicians (in process), rollout of OPR was highly successful and there were few access issues related to non-enrolled providers. DSS implemented a streamlined, short-form OPR-only enrollment process and consolidated all information related to the Ordering, Prescribing and Referring requirement at one link:

https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=Master+OPR+IM+11132013-DSS_approved.pdf&URI=Important_Message%2fMaster+OPR+IM+11132013-DSS_approved.pdf

The link below directs interested readers to a Frequently Asked Questions (FAQ), available as follows:
https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/OPR%20Enrollment%20FAQ.pdf

In relevant part, this FAQ clearly states the following:

Q: I do not want to become a provider in the Medicaid program, but I am willing to order, prescribe or refer Medicaid clients on an occasional basis. What do I have to do?

A: A provider must be enrolled as an Ordering/Prescribing/Referring (OPR) provider in order to order, prescribe or refer services for a Medicaid client. If you choose to enroll as an OPR provider, you will not be listed on the Medicaid program provider directory. In addition, enrolling as an OPR provider does not obligate providers to serve a specified or additional number of Medicaid clients.

- **That the Department adds a "separate look-up to include fully enrolled physicians".**
This recommendation is already available at the following link:
http://www.huskyhealthct.org/provider_lookup.html

Rates and Reimbursement

- DSS is open to the possibility of having a seminar for providers about the rate setting process.

- Providers can receive prior authorization through an electronic process or through a centralized 1-800 provider number. This has significantly expedited the process.

- DSS commented stating there are no sources of the rate identified, and it was not clear to which program the issues refer.

- During the committee meetings, DSS referenced the importance of data compiled by the Kaiser Family Foundation that compares state Medicaid rates to those paid by Medicare. The "State Health Facts Medicaid-to-Medicare Fee Index", updated with 2012 data, is available at the following link:

- http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/

- The information illustrates that Connecticut is actually comparably well situated to other states and the overall U.S. experience in these ratios:

2012	All Services	Primary Care	Obstetric Care	Other Services
United States	0.66	0.59	0.78	0.70
Connecticut	0.87	0.71	1.23	0.79

- Note that this report predates Connecticut's implementation in July 2013 of the ACA provision, requiring an increase Medicaid primary care rates for eligible primary care practitioners. This implementation nearly doubled many of those rates.

Capacity

- The State of Connecticut is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program. These include 1) use of an Administrative Services Organization (ASO) platform for Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services; 2) activities in support of improving access to preventative primary care; 3) efforts to support integration of medical, behavioral health, and long-term services and supports (LTSS); and 4) initiatives designed to "re-balance" spending on long term supports and services. Please see full report for further explanation of strategies.

- Community Health Network of Connecticut (CHNCT) and other ASO support members to enrolled providers.

- The AT&T Language Line services through the ASO are offered free of charge to providers. Culture Vision is provided free of charge to Person-Centered Medical Home (PCMH) practices.

- CHNCT provides considerable technical support to PCMH and "glide path" practices, and the Department is providing enhanced funding to PCMH practices.
- CHNCT is linking Medicaid beneficiaries to primary care through an attribution process.

Introduction

The purpose of this report is to address concerns about adequacy of the Connecticut Medicaid provider network in response to substitute Senate Bill No. 1026 Special Act No. 13-7: An Act Concerning an Adequate Provider Network to Ensure Positive Health Outcomes for Low-Income Residents.

The act requires the Council on Medical Assistance Program Oversight, or the subcommittee of the council, to study obstacles to achieving an adequate health care provider network for Medicaid recipients and make recommendations, to improve (1) recipient access to providers, and (2) health outcomes for such recipients across racial and ethnic lines.

 The study analyzed: (1) administrative burdens faced by providers, (2) the extent and benefits of provider education concerning provision of care to Medicaid recipients, and (3) the effect of Medicaid rates of reimbursement on achieving an adequate provider network.

The study identified strategies to (1) improve access to Medicaid providers by Medicaid recipients, (2) improve health outcomes of all Medicaid recipients, (3) reduce spending rates, particularly for the provision of care to Medicaid recipients with the costliest health needs, and (4) reduce racial and ethnic disparities in health outcomes.

By January 1, 2014, the Council must submit a report on its findings and recommendations, with a corresponding fiscal analysis, to the Public Health, Appropriations and Human Services committees of the General Assembly.

The Network Adequacy Committee of the Council on Medical Assistance Program Oversight met with providers so they could provide comments about inadequacies and suggest solutions and strategies to improve the Medicaid network. DSS has contributed data and current practices of their Medicaid and Husky Health Program. Community Health Network (CHNCT), the Medical Administrative Service Organization (ASO) has contributed information in this report. Contributors of the network adequacy group are listed in this report.

This report addresses the most frequently mentioned issues by Medicaid providers and advances potential recommendations for the Department of Social Services and the legislature to consider improving access in the Medicaid Provider network. These issues are:

1. Audit
2. Order Prescribing and Referring
3. Rates and Reimbursements.
4. Network Capacity

Implications of the Affordable Care Act (ACA)

The Affordable Care Act is expected to impact the Medicaid provider network in Connecticut dramatically because of the more than 60,000+ low-income adults, (HUSKY D members) are expected to enter the program in 2014. This could result in additional administrative burdens on providers that could potentially decrease access and increase barriers to care.

Current Husky Enrollment Report

Among others, these questions were raised about the expansion to Medicaid:
- Will Connecticut Providers be able to serve to an additional 60,000 people?
- Will workforce development be able to keep up with the demand for medical service?
- Can Connecticut keep enrolling Medicaid providers?
- Are there better methods for DSS communication with the provider associations about upcoming changes in the system, including mandated changes related to the Affordable Care Act?
- How can we measure whether the Medicaid expansion is resulting in better quality of care and outcomes?
- What have other states done with respect to rates?
- What are the best models of care and how can we expand them statewide?

This report attempts to answers to these questions.

Audit

Audits ensure ethical business practices, compliance with regulations, and the integrity of Connecticut's Medicaid program. With the persistent pressure to decrease inappropriate healthcare expenditures, both governmental and private payers will continue to use audits. According to the participants of the workgroup, the laborious preparation required for an audit is one of the most significant burdens providers encounter.

The following comments and concerns were raised by providers who participated on the audit issues and solutions subcommittee of the Network Adequacy Committee:

- That DSS auditors seem to approach audits with presumption of fraud and abuse in cases that may result from unintentional clerical errors;

- Most of the rules and regulations detailing billing processes are not transparent and have not been appropriately shared with providers.

- That the extrapolation method of auditing used by DSS should be modified because this method is not precise enough for determining the number of payment errors or the amount of overpayments to be collected.

- That audit errors are caused by out of date codes and methods that require manual intervention and special procedures to handle.

- That the DSS appeal process is frustrating and unproductive.

Solutions and Recommendations

The Audit Subcommittee proposed the following recommendations:

- That the extrapolation sampling process should be revised. And, assuming audit by extrapolation is a requirement of the Medicaid program, extrapolation should be performed across like-claims and across not the entire claims universe.
- That the intensity of DSS audits should be based on past audit results- agencies with higher compliance risk should be targeted instead of agencies that have performed positively in past audits. It is perceived by providers that DSS chooses larger agencies for their audit targets; they feel that instead, DSS should include all agencies or have an error rate threshold to identify subjects and schedules for audit.
- Provider responsibility for pursuing appropriate TPL- process results in an administrative burden on providers due to the labor-intensive back-end

review of services already provided and paid for. The intent of pursuing TPL is to ensure that, in accordance with federal law, Medicaid is the payer of last resort, not to find a provider liable, which is how the providers perceive the process.

- Establish external appeal process or establish an independent appeal process.
- Consider Third Party Liability Process (TPL), identifying appropriate payer (Medicaid or Medicare) up front.
- Change review process by requiring the assurance department to develop more prospective review but follow retrospective process for coming year.
- Provide information about the DSS audit process to Medicaid providers especially new providers, such as free training that would explain the proper entry of claims so as to avoid clerical errors. Provide an updated electronic manual online of audit rules, regulations, processes and contact information.

See Appendix A to see additional comments and report submissions from members of Network Adequacy committee.

DSS Comments

In November 2013, the State contracted with a vendor to create and implement a state-of-the-art fraud detection system designed to identify patters of fraud, waste and abuse perpetrated against state programs. Their focus is identifying systematic efforts to defraud the state through the use of enhanced analytics not currently available. These enhancements will not create redundancies with the ongoing compliance efforts to ensure accurate billing and payment. These efforts are focused on identifying fraudulent activity.

DSS would like to stress that audit adjustments are not made for unintentional clerical errors and that they understand and appreciate the significant difference between fraud and abuse and "overpayments". If fraud or abuse is discovered during an audit, the matter becomes an investigative matter no longer handled by the Audit Division. DSS is in the process of promulgating audit regulations that they believe will ensure transparency and provide the specificity the providers are requesting.

DSS believes in open and ongoing communication during the audit process. For that reason, they issue a preliminary report, which they believe is an important component of the process. Recipients of these preliminary reports are provided ample opportunity to address all issues identified. Providers have the right to appeal audits. In addition to a formal review, they can request that the Director of the Office of Quality Assurance (OQA) perform an "informal" review of a final audit report.

DSS explains that extrapolation is the cornerstone of their audit process and that without it; the audit process would be meaningless. The state supreme court has upheld the methodology. They use a statistically valid random sample where no claims are excluded from the universe selected for audit. Most providers perform multiple services so limiting sampling and extrapolation to unique services would not be practical. However, they do take into account the diversity of the claim universe when developing the sampling methodology. The design of an audit also takes into consideration a variation of claims in the selected universe. For instance, extremely large claims for wheelchairs are segregated from smaller claims for repairs to wheelchairs.

If there were an explicit direction that reviews be relaxed for providers that had not had issues in the past, then the state would be inviting bad behavior, because providers would know their claims would never be audited.

Provider appeals are performed outside the OQA. If a provider is not satisfied with the result of the appeal, he/she may pursue the matter in State court.

See other comments are in Executive Summary.

Ordering, Prescribing, and Referring

Ordering, prescribing, and referring requirements were created to inhibit and expose fraud, waste, and abuse in Medicaid programs. Under the Affordable Care Act, all providers, including ordering, prescribing, or referring (OPR) physicians, who provide services to HUSKY recipients must be enrolled in the Medical Assistance Program (CMAP). The OPR provider's NPI must be listed on every claim for services based on the order, prescription, or referral.

The Network Adequacy Group created a workgroup to identify issues and recommendations with ordering, prescribing and referring. The opinions provided below are from the provider groups and associations. During the time of the Subsequent to the discussions by the workgroup, DSS took several steps to resolve this issue and, their comments are located in the agency response section.

The main issues identified by the group are:

- Potential for significant access to care issues when patients are to discharged because physicians refuse to enroll or don't understand why they need to enroll.
- Provider look up on Husky Health website limited to just OPR enrolled.
- Potential for significant access to quality care issues - due to lack of enrollment (including specialists) and issues with filling prescriptions (interns/residents).
- Many physicians still unaware of requirement and confused about why they

should enroll.
- Lack of one clear document provided to all those expected to enroll that explains what needs to be done and how to do it.

Solutions and Recommendations

The participants of the workgroup also suggested three recommendations for strategies for improvements to OPR:

- Develop a common message for clients and, providers and, that Medicaid providers can give clients to follow up with their own non-enrolled providers. Develop more concise communication to currently non-enrolled physicians clarifying the requirement
- Improved communication with other agencies and stakeholders in advance of rollout of OPR and other Affordable Care Act requirements.
- Improved DSS website, provider look-up, and provider bulletins format.
  - Add separate look-up on Husky Health to include fully enrolled physicians, separate out physicians who still have capacity versus those not taking on any new cases. Provide an accurate list of all categories.

Rates and Reimbursements

The Network Adequacy Group also convened a workgroup on rates and the rate setting process. The opinions expressed below are from the provider groups and associations who participated.

Issues:

- CT's Medicaid rates are currently too low to cover costs for providers and to attract the number of providers the state will need.
- Rates do not cover everything that must be done to adequately care for people with vulnerable populations.
- There is a lack of transparency about the rate-setting process, and significant lack of provider involvement and feedback.
- Some rates haven't changed since the programs were implemented in 2008.
- The rate should be adjusted annually for inflation, given the volume of the projected demand of people qualified for Medicaid.
- Given the volume of care being given in the community, the projected increase in demand and the anticipated savings from Money Follows the Person (MFP) for the general fund.

Recommendations and Solutions:

- Adopt fair and transparent compensation models and review entire payment structure.
- Review other payment models different states have adopted.
- Provide quicker payments to providers.
- Increase payment rates. For example: payment structure should be flexible, and include reimbursements specifically for administrative work such as care coordination and time spent obtaining referral services.
- Expedite prior authorizations.
- Comprehensive review of CMS guidelines for Medicaid rates for behavioral health and services for individuals with disabilities, and how these guidelines match with the CT schedule of rates.
- Adjust CT's Medicaid rate schedule so that all services coverable under the federal guidelines are included so that providers may bill for services and the state will maximize its revenue with the 50% match (in some cases, higher for behavioral health).
- Identify needed administrative services and develop appropriate and specific reimbursement levels based on time spent and complexity of the services provided by the physicians and their office personnel.

See Appendix A for full report of comments from providers on rates and reimbursement.

DSS Comments
- The Department is open to the possibility of having a seminar for providers with the rate setting process.
- The Department is using a standard rate schedule and common service definitions for all services (as opposed to rates and service definitions that varied across the MCOs).
- Payment is made by HP, the reimbursement vendor, on a twice per month billing cycle.
- DSS does not have the authority to appropriate funds for rate increases.
- DSS has pointed the workgroup's attention to the following data compiled by the Kaiser Family Foundation that compares state Medicaid rates to those paid by Medicare. The "State Health Facts Medicaid-to-Medicare Fee Index", updated with 2012 data, is available at this link:

  http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/

  This report provides, in relevant part, the following, which illustrates that Connecticut is actually comparably well situated to other states and the overall U.S. experience in these ratios:

2012	All Services	Primary Care	Obstetric Care	Other Services

| United States | 0.66 | 0.59 | 0.78 | 0.70 |
| Connecticut | 0.87 | 0.71 | 1.23 | 0.79 |

Note that this report predates Connecticut's implementation in July 2013 of the ACA provision that required us to increase Medicaid primary care rates for eligible primary care practitioners who have attested. This nearly doubled many of those rates.

Capacity Issue

The Network Adequacy Group established a workgroup on provider capacity. The opinions expressed below are from the provider groups and associations who participated.

The issues are similar to the top issues discussed in private work groups. Please refer to each section and Appendix A (rates/reimbursements, OPR and audit) for further recommendations.

- Access to care issues. There is a lack of healthcare workers in each field to keep up with the demand of health care needs and rise in Medicaid enrollment. Some reasons why health care employers aren't hiring more: rates and reimbursement are too low to hire more qualified people and audits are taking over business with the administrative burdens. Difficult OPR procedures are making it difficult for physicians to write prescriptions and for Medicaid members to get their prescriptions.
- Patients and providers are having a difficult time understanding and navigating through health care systems and programs.
- Providers would like to provide a comprehensive PCMH system in their offices but lack the capacity and infrastructure.

Solutions and Recommendations

The workgroup recommended the **following solutions**:
- Expand the workforce: Provide incentives for potential health care workers and students to work in Connecticut. Collaborate with local associations for recruitment and retention.
- Have the Council on Medical Assistance Program Oversight review the ASO's current provider network and recruitment methods on a quarterly basis.
- Create Public service announcements on person-centered medical homes and how CT Medical Assistance Programs is becoming successful with them. Educate all practices about PCMH Program.
- Increase support for patient navigation services and increase patient education.

- Productively engaging patients in their own care and strong patient-provider relationships are critical to making the system work. Patients are often confused about program policies and turn to their providers as trusted sources for information. Many practices noted that better information, both directly to patients and for them to give patients, would ease that burden.
- Provide free telephonic translation services. On-call translation services for Medicaid providers and members. Free language courses for provider staff.
- Better information for consumers: patients face confusion while navigating the programs and rely on providers for help.
- Recruit more physicians, especially for referrals
- Give providers better information on patients: addresses, contact information, current and prior use of other services, and support with electronic medical records.
- Identify physician champions to help recruit their colleagues into public programs.
- Improve coordination of transportation services to reduce costly missed appointments.

Provider Report and Input in Appendix A.

DSS Response

- The State of Connecticut is employing diverse strategies to achieve improved health outcomes and cost efficiencies in the Medicaid program. These include 1) use of an Administrative Services Organization (ASO) platform for Medicaid medical, behavioral health, dental and non-emergency medical transportation (NEMT) services; 2) activities in support of improving access to preventative primary care; 3) efforts to support integration of medical, behavioral health, and long-term services and supports (LTSS); and 4) initiatives designed to "re-balance" spending on long term supports and services. Please see full report for further explanation of strategies in Appendix A.
- **Person-Centered Medical Homes (PCMH).** DSS implemented Person-Centered Medical Home (PCMH) initiative on January 1, 2012. The premise of a PCMH is that it enables primary care practitioners to bring a holistic, person-centered approach to supporting the needs of patients, while reducing barriers to access (e.g. limited office hours) that have inhibited people from effectively using such care. Through this effort, the Department is investing significant resources to help primary care practices obtain PCMH recognition from the National Committee for Quality Assurance (NCQA). Practices on the "glide path" toward recognition receive technical assistance from CHN-CT. Practices that have received recognition are eligible for financial incentives including enhanced fee-for-service payments and retrospective payments for meeting benchmarks on identified quality measures; practices on the glide path receive prorated enhanced fee for service payments based upon their progress on the

glide path but are not eligible for quality payments at this time. Key features of practice transformation include embedding limited medical care coordination functions within primary care practices, capacity for non-face-to-face and after hours support for patients, and use of interoperable electronic health records (EHR).

- **Demonstration to Integrate Care for Medicare-Medicaid Enrollees (Duals Initiative).** Connecticut has submitted an application for implementation funding under the federal Demonstration to Integrate Care for Dually Eligible Individuals. This is a managed fee-for-service model. The Connecticut proposal seeks to integrate Medicare and Medicaid long-term care, medical and behavioral services and supports, promote practice transformation, and create pathways for information sharing through key strategies including: 1) data integration and state of the art information technology and analytics; 2) Intensive Care Management (ICM) and care coordination in support of effective management of co-morbid chronic disease; 3) expanded access for Medicare and Medicaid Eligibles (MMEs) to Person Centered Medical Home (PCMH) primary care; and 4) a payment structure that will align financial incentives (advance payments related to costs of care coordination and supplemental services, as well as performance payments) to promote value. The MME initiative will create new, multi-disciplinary provider arrangements called "Health Neighborhoods" through which providers will be linked through care coordination contracts and electronic means.
- **Health Homes for Individuals with SPMI.** DSS is working with the Department of Mental Health and Addiction Services to implement health homes for individuals who are diagnosed with an identified Serious and Persistent Mental Illness (SPMI), have high expenditures, and are served by a Local Mental Health Authority (LMHA). As conceptualized, this model is anticipated to make PMPM payments to LMHAs that will permit them to incorporate APRNs within their existing models of behavioral health support.
- **Strategic Plan to Rebalance Long-Term Services and Supports.** This plan details diverse elements of a broad agenda that is designed to support older adults, people with disabilities and caregivers in choice of their preferred means, mode and place in which to receive long-term services and supports (LTSS). Key aspects of the plan include 1) continued support for Money Follows the Person; 2) State Balancing Incentive Payments Program (BIPP) activities; 3) nursing home diversification; and 4) launch of a new web-based hub called "My Place". The strategic plan identifies 'hot spots' for development of services, including medical services, since it projects demand attributed to the aging population at a town level.
- **Money Follows the Person.** The Money Follows the Person (MFP) initiative that has led efforts toward systems change in long-term services and supports. In addition to its work in having transitioned over 1,700 individuals from nursing facilities to the community, MFP is implementing diverse strategies that support reform. Key MFP demonstration services include: care planning specialized in engagement and motivation strategies, alcohol and

substance abuse intervention, peer support, informal care giver support, assistive technology, fall prevention, recovery assistance, housing coordination, self-directed transitional budgets including housing set-up, transportation assistance and housing modifications. Systems focus areas for MFP include housing development, workforce development, LTSS service and systems gap analysis/recommendations and hospital discharge planning interventions. An additional key aspect of the demonstration is the development of improved LTSS quality management systems. In 2012, the Governor has publicly committed to a significant expansion in the target for individuals transitioned, to a total of 5,000 individuals.

With respect to items over which we do have control

- CHNCT and the other ASOs support members in being referred to enrolled providers.

- CHNCT already successfully utilizes the AT&T Language Line (from January 1, 2013 – September 30, 2013, CHNCT Health Services used the service 4,462 times for 36 languages and CHNCT Member Services used the service for 10,500 language line interpretations, 304 face-to-face interpretations and 54 sign language interpretations) and Culture Vision (for 52 cultures) and does not require additional interpreter services.

- The AT&T Language Line services through the ASO are offered free of charge to providers. Culture Vision is provided free of charge to Person-Centered Medical Home (PCMH) practices.

- CHNCT provides considerable technical support to PCMH and "glide path" practices, and the Department is providing enhanced funding to PCMH practices.

- CHNCT is linking Medicaid beneficiaries to primary care through an attribution process.

- Outside the body of the report, the Department would also like to respond to this comment, which was included in the document entitled "Capacity Comments": *"Regarding access to care, there are few providers, especially dental providers, available."*

This statement is not reflective of the current experience in Connecticut Medicaid. As was reported to MAPOC on October 11, 2013, in the "HUSKY Health Program and Charter Oak Health Plan Medical ASO Program Dashboard Highlights", as of June, 2013 there were 18,019 providers participating in Medicaid. This contrasts with only 14,027 in January, 2012 (the month in which the state converted to managing its Medicaid medical services to an ASO arrangement).

Additionally, with respect to dental services, as of October 31, 2013, there were 1,799 dental providers enrolled in the CTDHP and 42 dental provider applications in progress of being credentialed and approved. This equates to more than one-half of the active licensed dentists in Connecticut and 50 active public health hygienists currently providing care as a network provider in the CTDHP program. Of the 1,799 dentists, 1,432 are new to the CTDHP program while 367 participated with the State of Connecticut managed care and fee for service programs before the implementation of the CTDHP on September 1, 2008.

Since the inception of the CTDHP in 2008, the network growth has maintained an average calendar yearly growth rate above 10%. For calendar year 2013, the network growth rate is at 11.1%, which equates to 180 newly enrolled providers to date. The number of primary care dentists, which are comprised of pediatric dentists and general dentists, is 1,498 dentists available to the HUSKY Health population. The enrollment of HUSKY Health clients eligible to receive dental services for October 2013 was 634,761 clients; which equates to 424 clients per primary care dentist. The average patient to dentist ratio is ~5,000 patients to every dentist nationally.

An in-depth analysis of the member to provider network demonstrates that the CTDHP has maintained and exceeded the network standards of having 1 dentist available for every 2,400 members as stipulated in the vendor contract. A geo access analysis shows that 100% of the Medicaid clients have the choice of at least two dentists within a 20 mile radius of their home; 99.7% of the members have 2 providers available within a 10 mile radius of their home; and 97.7% of the HUSKY Health members have 1 dentist available within a 5 mile radius of their place of residence. In fact, because of a recent trend of dental practices contacting the CTDHP to request additional patients, it was decided to collect the requests to be counted as a potential metric as the number of access points has exceeded the demand for dental services.

Geo Access, Network Growth, and Provider Relations Network Development

The Network Adequacy group requested information from DSS and CHNCT about Geo Access Results, Network Growth, and Provider Relations Network Development Outreach/Assessment for Husky D, and Action Steps for each category.

The information provided below illustrates the current state of network capacity in the Medicaid Provider Network. Please note the geo access report is only for Medicaid enrolled providers.

Geo Access was run in October 2013 with the industry standard of 1 specialist within 20 miles. **The specialists used in this reporting are the top specialists seen by HUSKY D members based on 2012 and 2013 utilization data.** CHNCT was requested to also run **Geo Access with the standard of 1 specialist within 10 miles**. The results are listed below:

In the chart below are the top provider specialist types utilized by the current Husky D membership.

Specialist	1 Provider : 10 Miles Capacity	1 Provider : 20 miles Capacity
Cardiology	97.9%	100%
Gastroenterology	96.5%	98.5%
General Surgery	99.2%	100%
Internal Medicine	98.6%	100%
Neurology	95.8%	100%
OB/GYN	99.4%	100%
Optometry	99.5%	99.9%
Orthopedic	97.8%	100%
Otology, Laryngology, Rhinology	97.1%	100%
Urology	95.6%	99.8%

Network Growth

The Network Adequacy Committee also asked for a breakdown of MD growth vs. other provider types. Below is a chart outlining the growth of the MDs and other providers in the CMAP (CT Medical Assistance Program) network.

Most Primary Care Physicians (PCPs) have had a substantial growth in the past 18 months.

PCP PHYSICIAN	Jan 2012	Jan 2013	Nov 2013	
FAMILY PRACTITIONER	317	390	520	
GENERAL PRACTITIONER	8	10	19	
GERIATRIC PRACTITIONER	5	11	16	
INTERNAL MEDICINE	531	784	1,113	
GENERAL PEDIATRICIAN	498	602	701	
PEDIATRIC ADOLESCENT MEDICINE	3	29	72	
Totals	**1,362**	**1,826**	**2,441**	**+1079**
OTHER PRACTITIONERS				
PEDIATRIC NURSE PRACTITIONER	78	114	144	
FAMILY NURSE PRACTITIONER	133	203	280	
NURSE PRACTIONER-OTHER	23	48	61	
ADULT HEALTH NURSE PRACTITIONER	1	23	53	
PHYSICIAN ASSISTANT	17	2		
GERIATRIC NURSE PRACTITIONER		1	7	
PRIMARY CARE NURSE PRACTITIONER		2	23	
MEDICAL PHYSICIAN ASSISTANT	1	49	41	
PRIMARY CARE PHYSICIAN ASSISTANT	7	102	168	
Totals	**260**	**544**	**777**	**+517**

Provider Relations Network Development Outreach/Assessment for HUSKY D

Key Specialty Recruitment:

As part of the planning for 2014, the HUSKY D 2012-2013 utilization and demographic data was evaluated to identify and target key provider types by specialty and location to meet the expected influx of HUSKY D members in 2014 (50,000-85,000).

Results:
- Identified 11 top cities: Hartford, New Haven, Bridgeport, Waterbury, New Britain, Stamford, Meriden, East Hartford, Norwich, West Haven and Danbury are where current members are located and where projected influx of new members will reside in 2014.

Current Action Steps:

- **GeoAccess**
  o Run reports using (10 and 20 mile standard) for each of the 11 top provider specialists by regions to identify any gaps for immediate targeted outreach. (See chart for results)

o **Attestation Provider Outreach (Priority)**
  o Provider Relations staff are reaching out to Providers who are receiving the enhanced ACA rates and to those who currently have a closed panel.
    o These providers are more likely to open their panels vs. other providers.
    o Approach provider's on the top 11 specialist's list first, then all other provider types

o **Outside Vendor Contract**
  o CHCNT contracted with an outside vendor to identify those providers who are non CMAP enrolled in CT. The file has been received and these providers have been prioritized and are being targeted for recruitment by the Provider Relations staff.

o **Outreach to Re-enrollment and Terminated CMAP Providers**
    o Produce a monthly file that contains providers identified as 60-day Pre-reenrollment so that outreach can be done proactively to remind providers to re-enroll and assist with any questions.
    o Produce weekly provider termination file of providers scheduled to be terminated from the CMAP network. Provider Relations proactively reaches out to these providers to request they remain in the CMAP network.

o **OPR (Pharmacy/Medical)**
  o Receive daily files from DSS/HP that identifies non OPR/CMAP providers. Provider Relations provides outreach to the providers on this file to have them enroll as an OPR or CMAP provider and is also doing targeted outreach to those providers who are key HUSKY D providers.

Department of Social Services Existing Initiatives
There was discussion among the membership of the network adequacy group about existing DSS programs and initiatives that promote positive better health outcomes, savings, enrollment and better quality of care.

The existing program and initiatives include:

1.) PCMH (Person-Centered Medical Home)
2.) Obstetric Pay for Performance (P4P)
3.) Dental Health Partnership

Person- Centered Medical Home

A Person-Centered Medical Home provides person-centered, comprehensive and coordinated care. Care is organized around a person and led by a primary care provider and/or a team of practitioners who facilitate and coordinate a person's healthcare needs with other healthcare professionals. Person-Centered Medical Homes improve access to care, improve efficiency of care, and improve coordination of care resulting in improved quality of care
(Source: www.huskhealthct.org)

If a practice wishes to participate in the PCMH Program they simply apply and depending if they have already achieved medical home recognition through NCQA at a Level 2 or 3, they may seek assistance to achieve recognition from NCQA through the Glide Path. The PCMH Program provides an enhanced fee reimbursement rate for practices that have reached or are seeking to attain NCQA recognition. The Glide Path Program provides technical assistance and enhanced fee to practices that wish to become NCQA.

Department of Social Services contracts with CHNCT, the Medical ASO to recruit new practices to apply to the program, assist with Glide Path, and provide technical assistance in the Joint Commission PCMH accreditation.

http://www.huskyhealthct.org/pathways_pcmh/pathways_faqs.html

Policy Transmittal

Current Status of Connecticut PCMH –Status and Data are from 12/5/2013
Source: http://www.cga.ct.gov/med/comm1.asp?sYear=2013

Obstetric Pay for Performance

The Obstetric Pay for Performance Program (P4P) is a new initiative of the Department of Social Services in cooperation with Community Health Network of Connecticut (CHNCT). The goal of the program is to improve the quality of care and birth outcomes of pregnancies covered by the Medicaid Program by incentivizing obstetric providers' performance for meeting a series of quality measures. The measures were chosen in collaboration with obstetrics providers and the Medical Assistance Program Oversight Council's Women's Health Committee, which will help oversee the program's progress.

Background:
The Department of Social Services is reforming the ways it pays providers for care to maximize recipient's clinical outcomes and the value of the care rendered. DSS currently pays for 4 of every 10 births in Connecticut; of these, almost 40% of deliveries are by Caesarean section, almost double the rate called for in national benchmark goals. Many of these deliveries are pre-term, resulting in excessive numbers of preventable NICU admissions and excessive preventable costs. The goal of the Pay for Performance program is to show that incentivizing better performance will help promote better quality of care and better outcomes for the patient.

Measures:
An online obstetric notification form is used to collect P4P data, as well as to inform DSS of the pregnancy and any associated risk factors in order for CHNCT to best target its Intensive Care Management services. The forms were available starting August 1, 2013 (as of September 2013, 429 OB notification forms have been completed). CHNCT provides ongoing technical assistance on the OB Notification Form.

Specific measures for which providers will receive incentive payments are:

- Timely completion (within 14 days) of online obstetrics prenatal and post-partum notification forms
- A first obstetric visit within 14 days after confirmation of pregnancy
- At least one postpartum visit within 21-56 days after delivery
- Full-term, vaginal delivery after spontaneous labor whenever medically possible
- Appropriate use of 17-alpha hydroxy-progesterone, which prevents pre-term birth.

Providers eligible for participation include family medicine physicians, obstetrician/gynecologists, obstetric nurse practitioners, family medicine nurse practitioners, physician assistants and certified nurse midwives. Care provided on dates of service between 7/1/2013 through 6/30/2014 will be eligible for the P4P payment.

The Connecticut Dental Health Partnership
***CTDHP* Dental Program for Most Improved State in the United States- Dr. Donna Balaski**

The Full Report is available here: The CT Dental Health Partnership

Coverage

The CT Dental Health Partnership provides comprehensive dental coverage for children (under the age of 21) and adults. Pediatric dental fees are on par with commercial rates of reimbursement. Adult rates were raised slightly and are set at 52% of the children's rates. Children and adults enrolled in HUSKY A do not have a cost share.   There is some cost sharing with the HUSKY B clients for services such as restorative dentistry (fillings), endodontics (root canal treatments), prosthodontics (crowns and partial dentures), oral surgery and orthodontia (braces), since HUSKY B mirrors commercial plan products that people can purchase for children under 19 years of age. Overall, the program is focused on improving access to oral health care, educating clients about oral health, building self-sufficiency and reducing barriers to provider participation. The CTDHP is working to instill the concept of a primary care dentist (PCD) and the importance of a Dental Home for all clients. Parents are encouraged to bring their children to a dentist by the child's first birthday to develop good oral health habits and have routine care. Additional professional outreach activities are provided to partner organizations, providers and community advocates.

Most notably, the CTDHP has partnered with the provider community to engage the dentists to enroll in the CTDHP.   All provider specialties (as well as stakeholder groups and agencies) participate in the "Dental Policy Advisory Council" or DPAC for short.

Provider Network

As of September 30, 2013, there are 1,753 dental providers enrolled in the CTDHP and 57 dental provider applications in progress of being credentialed.   This equates to more than half of the active dentists in Connecticut and 50 active public health hygienists currently providing care in the CTDHP program. Of the 1,753 dentists, 1,386 are new to the program while 367 participated with the State of Connecticut programs before the implementation of the CTDHP on September 1, 2008.

Fiscal Impact
The Office of Fiscal Analysis analyzed the fiscal impact of some of the proposed recommendations.
Provide Free Interpretation Services- It is our understanding the terms of the current agreement with the ASO requires them to provide interpreter services as needed. Therefore there is no additional cost anticipated to the DSS or the state to provide those services as long as they are in accordance with the current ASO contract and capabilities.

Establishing a Provider Ombudsman position to address provider questions and outreach would cost approximately $81,033 to $110,494 in salary and between $29,707 to $40,507 in fringe benefits. This estimate is based on the DAS position for the Long Term Care Ombudsman, MP -64 pay grade.

External Appeals Process- the Office of Fiscal Analysis used an analysis of a creation of office of administrative appeals and felt it would be applicable to this recommendation. See Attachment in Appendix A for full analysis.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 09 $	FY 10 $
Office of Administrative Hearings	GF - Cost	499,150	466,930
Comptroller Misc. Accounts (Fringe Benefits)[1]	GF - Cost	64,960	82,148
Department of Public Works or Office of Administrative Hearings	GF - Potential Cost	285,000	185,000
Human Rights & Opportunities, Com.	GF - Savings	86,000	86,000
Social Services, Dept.	GF - Cost	Potential	Potential

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill results in significant cost to establish a new state agency, the Office of Administrative Hearings (OAH). Two additional positions[2] and office space to house approximately twenty seven staff members would be required under the bill. In addition, it is anticipated that a state cost would be incurred to raise the salaries of

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[1] The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller. The first year fringe benefit costs for new positions do not include pension costs. The estimated first year fringe benefit rate as a percentage of payroll is 25.36%. The state's pension contribution is based upon the prior year's certification by the actuary for the State Employees Retirement System (SERS). The SERS fringe benefit rate is 33.27%, which when combined with the rate for non-pension fringe benefits totals 58.63%.

[2] 1 Chief Administrative Law Adjudicator Salary = $117,061; 1 Administrative Assistant Salary = $46,750.

hearing officers once they are designated as administrative law adjudicators under the bill and subject to the bill's stricter credentials.[3] Fringe benefits, training and education, and other expenses (e.g., court reporting, equipment leases) to run the new office would also be incurred.[4] These expenses would be incurred regardless of whether or not additional office space is required. (See below.)

Funds in the amount of $163,000 have been included within sHB 5021 (the budget bill as favorably reported from the Appropriations Committee) to support the agency's operations effective April 1, 2009.

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[3] Estimated annual cost for the salary differential of 23 hearing officers = $123,000.
[4] The office expenses are based on the actual costs of a state agency of similar size, the Freedom of Information Commission. (FY 07 = $180,000)

Summary and Conclusion

The Network Adequacy Workgroup identified provider issues and recommendations to the current Medicaid Provider Network serving Low-Income Adults. The primary areas providers had issues were with the audit process, ordering, prescribing and referring process, rates and reimbursement methodologies, and capacity of the Medicaid network. The provider community provided recommendations to some of the solve issues including creating an external appeals process, training and information available to new and current providers in the CMAP network in areas of audit, rates methodologies and OPR, and to also consider third party liability process. Along with receiving feedback from the provider community, the Department of Social Services provided feedback and responses to the provider issues and recommendations. The OPR issue was addressed prior to this report being finished and fact sheets became available. The audit and rates process were addressed in the reports and open conversations plan to continue. The Department's programs of incentivizing performance and quality were identified in this report. The report will be submitted to the Council on Medical Assistance Program Oversight and the Committees of Cognizance's of the General Assembly. The Council on Medical Assistance Program Oversight will continue to be an open platform for the provider community and DSS to discuss issues and recommendations regarding the current and future state of the Medicaid Provider Network.

Legislators
Rep. Elizabeth Ritter
Rep. Catherine Abercrombie
Sen. Gayle Slossberg
Report Prepared By:
Olivia G. Puckett,
Clerk of the Council on Medical Assistance Program Oversight,
Connecticut General Assembly

Appendix A Documents, Reports, and Summaries from Provider Groups and State Agencies

- Source: Taken from Enrollment Reports Council on Medical Assistance Program Oversight October 2013 Meeting
  Husky Enrollment Report
  http://www.cga.ct.gov/med/mh-meetings.asp?sYear=2013
  - Legislative Charge-
    http://www.cga.ct.gov/2013/act/sa/pdf/2013SA-00007-R00SB-01026-SA.pdf
  - Dental Health Partnership Report
  - Council on Medical Assistance Program Oversight Meeting 07-19-2013 and

    MAPOC 7-19-13.pdf   MAPOC 10-11-13 Medical ASO Utilizatio

    10-11-2013
  - Department of Social Services
    - Comments on Draft Report regarding issues of audit, rates, and OPR.

      DSS Comments on Draft Report of MAPC

      Connecticut Department of Social   Connecticut Department of Social
    - Provider Bulletin

      Provider Public and Secure Web Portals.p
    - Ordering, Prescribing and Referring Report

      MEDICAID PROVIDER AUDITS.p
  - OLR Report on Medicaid Provider Audits

    20131011ATTACH_Quarterly Eligibility Rep
  - Quarterly Husky Enrollment Report

    CHN contract excerpt - Section P Pr
  - CHNCT Contract on Network Adequacy
  - Medicaid Home Care Rates according to Home Care Association

Medicaid rates
survey results Oct-No

Dental Services for
Children and Parents

- CT Voices for Children- Dental Services Report

Provider Network
Adequacy research 1

- CT Assisted Living Research

June 2013 Report to
the Congress on Med

- MAPAC- Report on Chip and Medicaid Health Insurance

Medicaid Home Care   Home Care at Home
Home Care at Home   Home Care Network

- CT Association of Home Care at Home

Home Care at
Home12-10-12 CAHC

Leading Age CTHome   Leading Age CT
Care Program rates,   Memo to Medicaid Net

- Leading Age CT

Ellen Andrews CT
Health Policy Project

- Ellen Andrews- CT Health Policy Project

CSMS Primary Care   CSMS Network   CSMS Network
Survey Exec Summar   Adequacy Comments   Adequacy Comments

- CT State Medical Society

CSMS Medicaid Audit   CSMS 2009 Primary   CSMS 2008 Physician   CSMS 12-14-11   12-10-12
Regs Comments.pdf   Care Survey.pdf   Workforce Survey.pd   Prelim Medicaid-HUSK   CSMedicalSociety Med

Audit Guidelines for
PRI.DOCX

CHA middletown.pdf

- CT Hospital Association

CHCACT 9 10 13
Network Adequacy W

- CT Community Health Care Association

Adobe Acrobat
Document

- CT Association of Health Care Facilities

Entire Packet of
Information.pdf

- PDF of all submissions from Workgroup
- Ordering Prescribing and Referring Requirements and FAQ
- https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=Master+OPR+IM+11132013-DSS_approved.pdf&URI=Important_Message%2fMaster+OPR+IM+11132013-DSS_approved.pdf

- https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/OPR%20Enrollment%20FAQ.pdf
- Kaiser Report on Medicaid/ Medicare Rates
  http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/
- CT Medicaid Husky Provider Look-up
  http://www.huskyhealthct.org/provider_lookup.html
- CT Health Policy Project Report on Success in Medicaid
  - http://www.cthealthpolicy.org/briefs/201402_medicaid_success.pdf

2008SB-00201-R010
636-FN.DOC

- OFA Fiscal Analysis for Office of Administrative Appeals

Appendix B- Network Adequacy Members and Contributors

Department of Social Services
Office of Policy and Management
CT General Assembly – Office of Legislative Research, Council on Medical Assistance Program Oversight, Office of Fiscal Analysis
Rep. Elizabeth Ritter, Chair of the Council on Medical Assistance Program Oversight
Rep. Catherine Abercrombie, Chair of Human Services
Senator Gayle Slossberg, Chair of Human Services
Olivia Puckett- Clerk of Council on Medical Assistance Program Oversight
Michelle (Shelli) Dyer- Research Assistant – Council on Medical Assistance Program Oversight
CT Hospital Association
Connecticut State Medical Society
CT Community Providers Association
NAMI Connecticut
Leading Age CT
Connecticut Association for Healthcare at Home
Community Health Center Association of CT
CT Assisted Living Association
CT Association of Non Profits
CT Community Care
Sheila Amdur – Independent Consultant and Advocate
LARCC - Legal Assistance Resource Center of CT
CT Health Policy Project

Appendix C- Network Adequacy Committee Meeting dates

The workgroup met seven times.

July 17, 2013

September 10, 2013

October 22, 2013

November 6, 2013 Capacity subcommittee

November 7, 2013 Rate Setting subcommittee

November 12, 2012 Audit subcommittee

November 19, 2013